

Correspondence

Vitiligo in a COVID-19-vaccinated patient with ulcerative colitis: coincidence?

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Dear Editor,

The COVID-19 pandemic has been a global emergency since January 2020. It became clear that it could only be controlled by vaccines; fortunately, several vaccines were developed by the end of 2020. These include mRNA vaccines, which received approval from the US Food and Drug Administration for emergency use.¹ However, as time has passed, a number of adverse events (AEs) have been reported in association with all the vaccines. We report the possible association of vitiligo with the Pfizer-BioNTech vaccine BNT162b2 (Cominarty®) in a patient with ulcerative colitis (UC).

A 58-year-old man presented with white macular plaques distributed symmetrically across his face (Fig. 1), which had appeared 1 week after receiving his first dose of vaccine. The plaques were clinically consistent with vitiligo, and examination under Wood lamp confirmed the initial diagnosis. There were no vitiligo macules seen at any body site other than on his face, even on predilection sites such as the genitalia, axillae and dorsa of the hands, and there was no family history of vitiligo. The patient had a 2-year history of UC for which he was taking azathioprine and sulfasalazine.

The patient was diagnosed with vitiligo, and prescribed tacrolimus ointment twice daily. He attended for follow-up 1 month later, but there was no response seen.

Vaccines stimulate the immune system to produce antibodies. There are studies demonstrating that vaccines can trigger several autoimmune diseases in people with a genetic tendency to those diseases. Several autoimmune diseases, including multiple sclerosis, immune thrombocytopenic purpura and systemic lupus erythematosus have been linked to vaccines such as influenza, hepatitis B and the measles/mumps/rubella vaccines.²

Although no cutaneous AEs were encountered in Phase 3 studies of mRNA vaccines, several vaccine-related cutaneous AEs have been reported since the vaccines came into widespread use. These are generally mild and self-limiting, and include local injection-site reactions, delayed large local reactions, urticaria, morbilliform eruptions,

erythromelalgia, pernio/chilblains, filler reactions and pityriasis-rosea-like eruptions.³ Vitiligo or similar pigmentation-related cutaneous AEs have not been reported to date.

Our patient already had UC, which is an autoimmune disease. Patients with inflammatory bowel disease have been recommended to get a SARS-Cov-2 vaccine even if they are on anti-tumour necrosis factor treatment.⁴

For any treatment method, including vaccines, it is important to assess the risk-benefit balance in the prevention and treatment of disease. Some mild and self-limiting cutaneous AEs are a small risk in relation to the possible fatal outcome of COVID-19 infection. However, vitiligo is a disfiguring skin disorder that may result in stigma and consequent mental distress, particularly if present on visible areas such as the face.



Figure 1 Diffuse white patches consistent with vitiligo.

It is not clear if the vitiligo in our patient was caused by vaccination, as patients with pre-existing autoimmune diseases are more likely to also develop other autoimmune diseases.⁵ However, the temporal relationship between the vaccine and development of the disease is interesting, and further work is needed to demonstrate a causal relationship between vitiligo and COVID-19 vaccination in patients with autoimmune disorders.

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H. Aktas  and **G. Ertuğrul** 

Department of Dermatology, Karabuk University Faculty of Medicine, Karabuk, Turkey

E-mail: aktashabib@hotmail.com

Conflict of interest: the authors declare that they have no conflicts of interest.

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